		I AND HUMAN SERVICES  & MEDICAID SERVICES	into		FORM	1 APPROVEI 1. 0938-039
STATEMENT	F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI B. WING	· · · · · · · · · · · · · · · · · · ·	(X3) DATE S COMPLI	SURVEY
		155319	B. WING		02/0	7/2011
	OF CLINTON THE	· · · · · · · · · · · · · · · · · · ·		REET ADDRESS, CITY, STATE, ZIP CODI 375 S 11TH ST CLINTON, IN 47842	<b>.</b>	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	ទេ -	F 000			
A CONTRACTOR OF THE PARTY OF TH	IN00084624 and IN Complaint IN00084 deficiencies related F223, F224, F225, Complaint IN00085 lack of evidence. Survey dates: 2/3, 2 Facility number: 000 Provider number: 1 AIM number: 10028	624- Substantiated, to the allegations are cited at and F226.  086- Unsubstantiated due to 2/4, and 2/7/11		Preparation and/or execution of to of correction, in general, or this caction in particular, does not consummed admission or agreement by this fit the facts alleged or conclusions so in this statement of deficiencies. Of correction and specific correct are prepared and/or executed in caction with state and federal laws.  RECEIVE	corrective stitute an acility of et forth The plan ive actions ompliance	
944h"	Survey team: Teresa Buske, RN / Mary Weyls, RN Laura Brashear, RN Census bed type: SNF/NF: 82 Total: 82 Census payor type: Medicare: 11 Medicaid: 55 Other: 16 Total: 82			FEB 2 8 20  LONG TERM CARE DIVI INDIANA STATE DEPARTMENT	SION	
i	in accordance with	eleted on February 10, 2011		ENTERED MAR	1 2011	
BORATORY		ER/SUPPLIER REPRESENTATIVE'S SIGN	ATURE	Administrator	02/	(X8) DATE 25/2011

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: G9ZH11

Facility ID: 000212

If continuation sheet Page 1 of 33

PRINTED: 02/11/2011

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		LE CONSTRUCTION	(X3) DATE S	
			A. BUIL	DING			С
		155319	B. WIN	G		02/0	07/2011
	PROVIDER OR SUPPLIER  S OF CLINTON THE			375	EET ADDRESS, CITY, STATE, ZIP CODE 5 S 11TH ST LINTON, IN 47842		
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F 223 SS=D	ABUSE/INVOLUNT The resident has the sexual, physical, and punishment, and interview and interview, the facility were free from physical abuse, of interview, the facility were free from physical and oriented, utilized and oriented, utilized and oriented, utilized.	e right to be free from verbal, ad mental abuse, corporal voluntary seclusion.  It use verbal, mental, sexual, corporal punishment, or on.  It is not met as evidenced view, observation and y failed to ensure residents sical abuse for 2 of 2 residents taff abuse i.e. "rough care" ated" in a sample of 22. (and F).  on 2/3/11 at 1:20 p.m., the indicated Resident F was alerted wheelchair propelling self,	F2	23	It is the intent of this facility for all residents to be free from physical all.  1. CORRECTIVE ACTIO CNA #10 was placed on an im suspension. A thorough invest was completed, including intent Resident F, other residents can by CNA #10, and staff member have worked with and around. The investigation revealed that was no intentional harm placed by CNA #10, and CNA #10 dit think Resident F was going to CNA #10 was provided with a inservice to patient care and stream of the conflict, RN #4 removed CNA caring for Resident F for the resident F	buse.  N: mediate tigation rview of red for rs who CNA #10.  t there id truly bite her. directed ress.  a written a potential #10 from mainder of e regarding e in relation from	
	On 2/3/11 at 2:30 p. from an investigation Checklist," dated 1/5 by the Administrator "Report of Concern Sunday 01/02, [CNA [Resident F]. [Resident Hat was across the she had a lot to do a Stated 'She had both to take the call light a	m., documentation was noted in titled "Allegations of Abuse 5/11, for Resident F provided . The documentation included "form, dated 1/5/11, of "On a #10] had an altercation with ent F] wanted her blanket, room. States [CNA #10] said and was flickering her hands. In of her arms on her right arm away and my arm twisted."			CNA #9 was suspended on 01/2 and was terminated from emplo on 01/28/11. A thorough inves began on 01/26/11, including in Resident C, other residents care by CNA #9, and other staff mer who worked with and around C Although, in the survey it revea CNA #7 stated this had also occ in December. This information not stated in the initial interview 01/26/11. However, additional and proper identification of CN concluded immediate terminatic CNA #9 at the conclusion of the investigation.	oyment tigation nterview of ed for nbers NA #9. led that curred was v on allegations A #9 on of	

•	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		PLE CONSTRUCTION	(X3) DATE SI COMPLE	
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	ROVIDER OR SUPPLIER  OF CLINTON THE			3	REET ADDRESS, CITY, STATE, ZIP CODE 75 S 11TH ST CLINTON, IN 47842		
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F 223	me.' 'I don't know we thing.' 'Stated her a had no further come documentation indice "there was no intension has no prior history complaints. Resided #10] grabbed her. CNA we positioning her in being on CNA [CNA # exchange however, daughter] came [and arm and this report [CNA #10 was susptelephone pending in Interview of RN #4 indicated on 1/2/11 hallway and heard from. RN stated the bed and the door to RN indicated she enwhat was going on it stated she wanted her the dresser and CN to bite her. The RN to leave and she fin bed. The RN stated was going to bring the Administrator's attentiold the resident to the RN stated CNA was barred from Restated no injury was Interview of Resident	what made her think of such a rm felt sore but was fine and plaints." Further cated the facility determined tional abuse. The employee nor has received any prior nt [Resident F] states [CNA rm, CNA states resident was in the process of ed[RN #4] performed write 10] on 01/02/11 for verbal on 01/05/11 [Resident F and d] added the touching of the [and] investigation followed. Dended on 1/5/11 via investigation."  On 2/4/11 at 1:40 p.m., she was walking up the oud voices in Resident F's excepted the room and asked to CNA #10. The resident the room was closed. The intered the room and asked to CNA #10. The resident tried indicated she asked CNA #10 ished putting Resident F to the resident to the incident F's room. The RN inoted to the resident.  On 2/4/11 at 2:30 p.m., on the F on 2/4/11 at 2:30 p.m., on the fon 2/4/11 at 2:30 p.m., on the first plant is the first plant and it was her right.	F	223	Concern Form" on 01/24/11. Howe slid the form under the Administrate office door and due to meetings out of the office, was picked up by the Administrator on 01/26/11. RN # 5 was reinserviced of the proper policiand procedures regarding immediate reporting to the Administrator/Direct of Nurses of any allegations of abusin relation to removing the staff meeting from complete duty until an investigistic complete.  2. OTHERS IDENTIFIED:  Social Services completed a 100% a 02/08/11, of all residents and family to determine if there were any other of concern. No other areas of conceidentified.  3. SYSTEMS IN PLACE:  An inservice was held on 2/07/11 at 2/08/11 for all staff to re-educate or policies and procedures for allegation of abuse. Licensed nurses received additional training on the proper protocal of: dismiss employee from current shift; immediate notification of the Administrator/Director of Nurses; initiate investigation.  4. MONITORING:  The Administrator/Director of Nurse will monitor during weekly routine QA rounds to ensure all staff are awoof the proper policies and procedure all immediate steps are properly corton ensure the safety of the residents. QA rounds will include random san of staff and residents to ensure residented from abuse.	cies e ector ee. mber gation  audit on y's areas ern were  and a current ons  arector  ing yare es and aducted inpling	
		oncerns with CNA #10 on it indicated the CNA had			·		

_	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	MBER: A. BUILDING COMPLETED				
		155319	B. WI			1	C <b>7/2011</b>
	PROVIDER OR SUPPLIER  S OF CLINTON THE		•	37	EET ADDRESS, CITY, STATE, ZIP CODE 5 S 11TH ST LINTON, IN 47842		_
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F 223	yelled at her for two The resident indica her about everythin while the CNA was while assisting her told the CNA she w picked up the call light e CNA came out both of her hands o call light away. The came in and sent the stated the nurse tole Administrator since The resident stated and then a few days went to the Administresident stated she CNA #10 since that continued to care for On 2/4/11 at 2:30 p.m., 8/20/10 of Resident rude and rushing duwarning was noted, walking by room [Reemployee and resid disagreement over lemployee say to resistates CNA attempt from me.' Resident pink 'Snuggie' blank on dresser."	days (1/2/11 being day two). ted the CNA had "yelled" at g and she was tired of it. So in the bathroom on 1/2/11 to bed, the resident stated she as going to report her and ght to use. The resident stated of the bathroom and placed on her right arm and took the resident then stated the nurse he CNA out. The resident d her to report it to the it doesn't do them any good. she did not have any bruises a later she and her daughter strator to report CNA #10. The has not had any issues with time and indicated the CNA or her.  Im., Resident F was observed bed.  Innel file of CNA #10 on indicated a written warning on I with complaint of CNA being uring care. A second written dated 1/2/11, of "This nurse esident F room] heard	F	223	All Grievance forms will immedia presented to the Adm./Designee to if abuse of any type has occurred.  All Grievances will be reviewed m with the QA team and quarterly at meeting with the Medical Director ensure on-going compliance.  5. DATE COMPLETE: This plan of correction constitutes credible allegation of compliance wall regulatory requirements. Our da compliance is March 9, 2011.	determine onthly QA to our	

	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		PLE CONSTRUCTION G	(X3) DATE S COMPL	
	-	155319	B. WII	NG			C <b>)7/2011</b>
	ROVIDER OR SUPPLIER  OF CLINTON THE			37	REET ADDRESS, CITY, STATE, ZIP CODE 75 S 11TH ST CLINTON, IN 47842		
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	and 1/4/11 on 7-3 s  2. A facility investig on 2/3/11 at 2:30 p.  A "Compliment and dated 1/24/11. RN received by Resider states she does not that she is too rough she is always trying requests to not have A form titled "Allega 1/26/11, was noted.  Written interviews on noted within the written rough with [Reben resident's pants resident indicated shower that CNA #9 sprayed her sprayer. Documentarequested that CNA her.  During interview of Cothe CNA indicated should be caring for Resident caring for	hift.  ation of abuse was received m., from the Administrator.  Concern Form" was noted, #5 documented a concern for C indicating "Resident trust staff member et (and) in [with] her. She feels that to butter people up. She concern for her."  tions of Abuse", dated  f staff and residents were ten investigation.	F	223			
		d. CNA #7 indicated the					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		IPLE CONSTRUCTION	(X3) DATE S COMPLE	
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	ROVIDER OR SUPPLIER OF CLINTON THE			3	REET ADDRESS, CITY, STATE, ZIP CODI 175 S 11TH ST CLINTON, IN 47842	······································	772011
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·	indicated she told C caring for Resident went to the charge CNA #9 was rough indicated she could the charge nurse she Resident C's clinica 2/3/11 at 2:55 p.m.  An annual assessment indinterviewable require transfers and hygien Review of facility cutifled "Abuse-Respo 6/1/10 on 2/4/11 at is the intent of this finenvironment free of resident had the right sexual, physical, ar punishment, involund misappropriation of sometimes referredIdentification of abuse must be tainvestigated. The repolicies and procedud. If the allegation is or mental abuse of a designee, or staff mithe allegation will taken and the right sexual services and procedud. If the allegation is or mental abuse of a designee, or staff mithe allegation will taken and the right services and procedud.	"and started crying. CNA #7 CNA #9 she would finishing C. CNA #7 indicated she nurse and reported she felt with Resident C. CNA #7 not remember the name of he had reported to.  If record was reviewed on the name of he had reported to.  If record was reviewed on the name of he had reported to.  If record was reviewed on the name of he had reported to.  If record was reviewed on the name of he had reported to.  If record was reviewed on the name of he had reported to.  If record was reviewed on the name of he had reported to.  If record was reviewed on the name of he had reported to.  If record was reviewed on the name of he had reported to.  If record was reviewed on the name of he had reported to.  If record was reviewed on the name of he had reported to.  If record was reviewed on the name of he had reported to.  If record was reviewed on the name of he had reported to.  If record was reviewed on the name of he had reported to.  If record was reviewed on the name of he had reported to.  If record was reviewed on the name of he had reported to.  If record was reviewed on the had reported to.  If record was reviewed on the had reported to.  If record was reviewed on the had reported to.	F 2	223			
	in progress"						

STATEMENT OF DEFICIENCIES (X: AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUII	JLTIPLE CONSTRU DING	JCTION	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER			STREET ADDRES 375 S 11TH ST CLINTON, IN			
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	Continued From pa This Federal tag rel IN00084624. 3.1-27(a)(1)	ates to Complaint	F 2				-
F 224 SS=E	MISTREATMENT/N  The facility must de policies and proced mistreatment, negle	NEGLECT/MISAPPROPRIAT	F 2	It is the intresidents very property to the second of the	tent of this facility to ensurvere free of having their aken without their consent.  ECTIVE ACTION: the items were always replessed, and a thorough invacted for each occurrence. tigations did not reveal a survey.	aced vestigation	
	by: Based on interview failed to ensure resi their property taken 5 residents reviewe property in a sample and G ]  Findings include:  1. During initial tour 1:00 p.m., Resident oriented. At that tim interviewed. Reside months ago she had drawer in her room. enters her room oth housekeeping staff. had notified the Adn Director.	ent A indicated about three d \$65.00 missing from a The resident indicated no one er than nursing staff and The resident indicated she ninistrator and Social Service		2. OTHE Social Ser of all resid missing pr No other r  3. SYSTI An in-serv for all staf procedure taken with  4. MONI The Admi monitor d to ensure: policies ar if a reside their cons a random  Any/All M immediate	crices conducted a 100% and ents for any other concern roperty which was completed identified.  EMS IN PLACE:  vice was held on 2/07/11 at ff to re-educate on current is for residents who have prout their consent.  FTORING:  inistrator/Director of Nursi uring weekly routine QA rall staff are aware of the prout their consent with the property taken with ent. QA rounds will inclusive ampling of staff and residents who have property taken with ent. QA rounds will inclusive ampling of staff and residents when the property taken with ent. QA rounds will inclusive ampling of staff and residents when the property reports well given to the Administration, investigation, and residents.	udit us with ted on 02/08/1  and 02/08/11 policies and roperty  ing will rounds roper ken out de dents.  ill be ator	1.
		record was reviewed on The most recent Minimum					

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL	JLTIPLE CONS DING	TRUCTION	(×	(3) DATE S COMPLE	ETED	
		155319	B. WIN	G				C 7/2011	
	PROVIDER OR SUPPLIER S OF CLINTON THE			375 S 11TH	RESS, CITY, STATE, ZIP CO 1 ST 1, IN 47842	ODE	02.0		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		PROVIDER'S PLAN OF CO ACH CORRECTIVE ACTIO DSS-REFERENCED TO THE DEFICIENCY)	N SHOULI E APPROP	D BE	(X5) COMPLETION DATE	
F 224	Data Set [MDS] ass 11/29/10, assessed impairments.  On 2/3/11 at 2:30 p interviewed. The A resident was alert a Administrator indica was missing and it Administrator indica member who had to identify any certain done it.  A form titled "Comp 4/08, completed on concern of "\$50 mis [Resident A]. It was	sessment, completed on I the resident with no cognition I. The resident with no cognition I. The Administrator was dministrator indicated the and oriented. The ated the facility verified \$50.00 was replaced on 1/5/11. The ated they thought it was a staff aken the money, but could not staff member who might have claint/Grievance Form," dated 11/20/10, addressed the asing from hidden spot. Is there Thurs. [11/18/10], she 1/19/10] but it was gone after	F 2	All revi and the com	Missing Property Reports ewed at the monthly QA at the quarterly QA meet Medical Director to ensurabliance.  DATE COMPLETE: s plan of correction constitutes allegation of compliance gulatory requirements. Appliance is March 9, 2011	meeting ting with re on-goin itutes our ance with Our date			
	Takeninterview o resident's wing on 1 was made of CNAs, and the Resident's 1 had been there.  On 2/4/11 at 12:00 p(DON) was interviewed uring the investigal interviewed was Resident's 12:00 p(DON) was interviewed was Residenterviewed. The RI reported missing mothe DON and Social	he form addressed Action f staff who worked on the 1/19, and 20/10. A notation /staff individually interviewed ramily conferred the money  D.m., the Director of Nursing wed. The DON indicated tion the only resident sident A's roommate.  D.m., RN #3 was N indicated Resident D had oney, which was reported to Service Director [SSD]. RN rught it was in November or							

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUII		LE CONSTRUCTION	COMPL	ETED
		155319	B. WIN	G		02/0	C <b>7/2011</b>
	ROVIDER OR SUPPLIER OF CLINTON THE			37	EET ADDRESS, CITY, STATE, ZIP CODE 5 S 11TH ST LINTON, IN 47842	<del> </del>	
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F 224		•	F 2	24			
	a.m. The resident i money missing but soap and two new s she had personally	erviewed on 2/4/11 at 10:15 ndicated she had not had had a bottle of liquid body Suave deodorant sticks that purchased missing. The he had reported it to the SSD d looked into it.					
		.m. the SSD was interviewed. she didn't know anything			:		
	interviewed regarding Administrator indicated a report made by Remaining a bornissing. The Administration was unable to locate the	45 p.m., the Administrator was ng reports of concern. The sted that on 11/9/10 there was esident E's daughter of the bitle of Olay Body Lotion instrator indicated the searched and the facility was lotion. The Administrator was replaced on 11/18/10.					
		on 2/3/11 which began at #20, LPN #20 indicated t and oriented.					
	2/3/11 at 2:30 p.m., The investigation indinterviewed on 1/26, the resident indicate taken by 'sticky finge talcum powder taken taken from her and	on of abuse was received on from the Administrator. dicated Resident B was (11. Documentation indicated ed, "I have had candy and popers, (CNA #9). Also lotion and n. My roommate had pop I have seen her get in her the bottle of cranberry juice, ck."					
ļ	During interview of I	Resident B on 2/4/11 at 11:15					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDI	G		С	
		155319	B. WING_		1	7/2011	
	ROVIDER OR SUPPLIER  OF CLINTON THE		;	REET ADDRESS, CITY, STATE, ZIP CODE 375 S 11TH ST CLINTON, IN 47842			
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F 224	a.m., Resident B indicated she had sher bedside drawer had seen CNA #9 to such as cans of colonal to the had seen CNA #9 to such as cans of colonal to the had seen CNA #9 to the had s	dicated she has had talcum candy missing. The resident een CNA #9 take candy out of . The resident indicated she ake items from her roommate, ke. Resident B indicated she ake a drink out of a bottle of	F 224				
	the cap back on the she had told staff all During interview of the RN indicated the about CNA #9 takin and Resident H. RI	mate] cranberry juice and put bottle. The resident indicated bout CNA #9's behavior.  RN #3 on 2/3/11 at 3:35 p.m., at Resident B had told her g items from her (Resident B) N #3 indicated she told uld tell someone higher than					
	<ul><li>2/4/11 at 11 a.m. Ar 11/09/10, indicated</li><li>5. During initial tour</li></ul>	I record was reviewed on annual assessment, dated the resident as interviewable.  on 2/3/11 which began at #20, LPN #20 indicated rt and oriented.					
	p.m., the resident in family every other w when she would reta would have candy o indicated she told he her candy. The resi	Resident G on 2/3/11 at 2:05 dicated she goes out to visit eek. The resident indicated urn back to the facility she r lotion missing. The resident er family to just stop bringing dent indicated when she first they" told her not to keep					
	RN #4 indicated Res	RN #4 on 2/4/11 at 1:40 p.m., sident G came out of her as mad. The RN indicated					

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		LE CONSTRUCTION	(X3) DATE SI COMPLE	
		15531 <del>9</del>	B. WIN	G		1	C 7/ <b>2011</b>
	ROVIDER OR SUPPLIER  OF CLINTON THE			375	ET ADDRESS, CITY, STATE, ZIP CODE 5 S 11TH ST JINTON, IN 47842	· · · · · · · · · · · · · · · · · · ·	112011
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F 224	the resident was up lotion was missing. weekend option, so	set because a half of bottle of RN #4 indicated she worked she wrote a note concerning nd put it under the door of the	F2	24			
	titled "Abuse-Responded" titled "Abuse-Responded" is the intent of this from the intent of the int	their property (collectively, to as 'events. )' buse can occur in several ort/Complaints. All allegations					
	investigated. The repolicies and proced Based on findings of conclusion about the determined Step 1 involving mistreatme property, abuse, negresident shall be improperty, abuse, negresident shall be improperty, and everyone observationally, any period event, and everyone observations that such as a conclusion of the India Health as per the real Administrator or desinvestigate all allegations and procedured perpetrate.	aken seriously and must be aporting and investigation ures must be fully enforced. Investigation, a final e alleged abuse can be Any alleged violation ent, misappropriation of glect, or exploitation of a mediately reported to the stor of Nursing or designee(s). In son may report such an exist encouraged to report aggest an event has occurred ause exists to believe an Administrator is responsible and State Department of porting guidelines5. The signee shall thoroughly attions of an event7. If the or is an employee of the existence of the signee suspended until the					

1	AN OF CORRECTION IDENTIFICATION NUMBER:		1	ULTIP LDING	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		155319	B. WI	IG		02/0	C 07/ <b>201</b> 1	
	ROVIDER OR SUPPLIER  OF CLINTON THE			37	ET ADDRESS, CITY, STATE, ZIP 5 S 11TH ST LINTON, IN 47842			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	(X5) COMPLETION DATE		
	Director of Nursing Documentation and the event is comple suspected misapping for which you must Property Investigation related shall be reported to officials as soon as accordance with States and the event investigation related shall be reported to officials as soon as accordance with States are required by law within 24 hours of o Care Division CFR of facility must ensure involving mistreatment including injuries of misappropriation of immediately to the atto other officials in a through established State Survey and Cornel Review of facility cutitled "Abuse Prohibitat 1:40 p.m., indicate Resident Property exploitation, or wron	shall ensure the Incident Investigation Tool regarding ted unless the event is repriation of resident property use the Misappropriation of on Report12. Results of the It to the resident's incident the Department of Health reasonably possible, in late and Federal Law"  Interest policy and procedure musual Occurrences," dated 1:40 p.m., indicated " ences to be reported: Facilities to report unusual occurrences ccurrence to the Long Term 483.13(c)(2) states that 'the enthat all alleged violations ent, neglect, or abuse, unknown source and resident property are reported administrator of the facility and accordance with State Law procedures (including to the entification Agency."  Interest policy and procedure tion," dated 6/1/10, on 2/4/11 and " Misappropriation of The deliberate misplacement, gful temporary or permanent elongings or money without	F	224				
	This Federal tag rela IN00084624.	ates to Complaint	-			•		
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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED		
	•	155319	B. WING_		1	C 7/ <b>2011</b>
	ROVIDER OR SUPPLIER		3	REET ADDRESS, CITY, STATE, ZIP CODE 175 S 11TH ST CLINTON, IN 47842		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	Continued From pa 3.1-28(a)		F 224			:
F 225 \$S=E	The facility must not been found guilty or mistreating resident had a finding entereregistry concerning of residents or mistreating of residents or mistreating and report any known court of law against indicate unfitness for other facility staff to or licensing authority. The facility must entinvolving mistreatm including injuries of misappropriation of immediately to the atto other officials in a through established State survey and certain the facility must haviolations are thorough.	portional procedures of the State nurse aide or the State nurse aide registry ties.  Sure that all alleged violations ent, neglect, or abuse, unknown source and resident property are reported administrator of the facility and accordance with State law procedures (including to the entification agency).  Ve evidence that all alleged ughly investigated, and must intial abuse while the	F 225	alleged violations of physical abuse and/or misappropriation of resident property are immediately reported to the administrator or other officials, allegations are thoroughly investigate and further potential abuse is prevented.  1. CORRECTIVE ACTION:  An in-service was held on 2/07/11 and 02/08/11, for all staff, to re-educe on current policies and procedures for any/all allegations of abuse and/or misappropriation of resident property which included: protecting the reside by removing the person allegations at made against, immediately reporting Administrator/Designee, thorough investigation of all staff/residents involved.  2. OTHERS IDENTIFIED:  Social Service will conduct interview with all resident/family members to it any further complaints of abuse and/missing property. No other residents identified.  3. SYSTEMS IN PLACE:  All employees' were in-serviced on and 2/08/11 and each new hire will reservice included: Current Policie	ed.  ate or  c, ent re to  /s dentify or  2/07/11 ecceive es and	
	to the administrator representative and with State law (inclu- certification agency) incident, and if the a	vestigations must be reported or his designated to other officials in accordance ding to the State survey and within 5 working days of the alleged violation is verified we action must be taken.		procedures for allegations of abuse a misappropriation of resident property, protection of the resident, immediate reporting, thorough investigation of all staff/residents in and prevention of misappropriation of property and any type/kind of abuse.	volved of resident	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		155319	B. WIN	IG			7/2011
	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	37 CL	ET ADDRESS, CITY, STATE, ZIP CODE 5 S 11TH ST .INTON, IN 47842 PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	CORRECTION (X5) ION SHOULD BE COMPLETIO HE APPROPRIATE DATE	
F 225	This REQUIREMENT by: Based on record refailed to ensure all abuse and/or misar property for 7 of 7 rephysical abuse and property i.e. missing in that, 1) the allegal immediately to the action (ISDH); 2) allegation investigated as all sinterviewed and/or conterviewed and, 3) not prevented during allegations were allegations were allegations.	view and interview, the facility alleged violations of physical oppropriation of resident esidents with allegations of for misappropriation of their g property in a sample of 22; ations were not reported administrator or other officials ns were not thoroughly staff involved were not other residents were not further potential abuse was g investigations as staff with owed to work after the iced by residents. (Residents	F 2	225	4. MONITORING: The Administrator/Director of Nurmonitor during weekly routine QA to ensure all staff are aware of the policies and procedures and appropriates are taken for allegations.  ADM/Designee will monitor/review of any suspected abuse and/or Miss resident property, as any occur, ear morning QA stand-up meeting to epolicy/procdures are being followed.  ADM/Designee will review all alled And misappropriation of resident property at the QA meeting with the IDT at the QA meeting with the Medical State of Complete Co	rounds proper propriate  w all allegation appropriation of the am during the mature facility ad.  egations of abus property at the c; and quarterly al Director.  our with	e e
	Director of Nursing and oriented, utilize and participating in On 2/3/11 at 2:30 p. from an investigatio Checklist," dated 1/5 by the Administrator "Report of Concern' Sunday 01/02, [CNA [Resident F]. [Resident F]. [Resident F] and a lot to do a Stated 'She had bot	on 2/3/11 at 1:20 p.m., the indicated Resident F was alert d wheelchair propelling self, therapy currently.  m., documentation was noted in titled "Allegations of Abuse 5/11, for Resident F provided The documentation included form, dated 1/5/11, of "On A #10] had an altercation with ent F ] wanted her blanket, room. States [CNA #10] said and was flickering her hands. In hor her arms on her right arm away and my arm twisted.					

_	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUIL	JLTIPLE CONSTRUC			COMPLI	ETED
		155319	B. WIN	G				C <b>7/2011</b>
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 375 S 11TH ST CLINTON, IN 47842					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG	X (EACH	VIDER'S PLAN OF CORRECTIVE AC REFERENCED TO DEFICIENC	TION SHOU THE APPRO	LD BE	(X5) COMPLETION DATE
F 225	'She jerked her han me.' 'I don't know w thing.' 'Stated her a had no further come documentation indic "there was no intenhas no prior history complaints. Resider #10] grabbed her an grabbed her. CNA w positioning her in be up on CNA [CNA # exchange however, daughter] came [an arm and this report [CNA #10 was susptelephone pending interview of RN #44.	d away and said Don't bite hat made her think of such a rm felt sore but was fine and plaints." Further cated the facility determined tional abuse. The employee no has received any prior nt [Resident F] states [CNA rm, CNA states resident was in the process of ed[RN #4] performed write 10] on 01/02/11 for verbal on 01/05/11 [Resident F and d] added the touching of the [and] investigation followed. ended on 1/5/11 via nvestigation."	F 2	25				
	indicated on 1/2/11 hallway and heard he room. RN stated the bed and the door to RN indicated she er what was going on the stated she wanted if the dresser and the tried to bite her. The CNA #10 to leave a Resident F to bed. Indicated she was going the Administrator's a told the resident to the RN stated CNA was barred from Re stated no injury was RN stated she wrote regarding verbal resident to the stated she wrote regarding verbal resident she wrote regarding verbal resident to the stated she wrote regarding verbal resident she wrote regarding verbal resident to the stated she wrote regarding verbal resident she wrote resident she wrote regarding verbal resident she was she wrote regarding verbal resident she was s	she was walking up the bud voices in Resident F's resident was being put to the room was closed. The need the room and asked to CNA #10. The resident per pink blanket which was on CNA indicated the resident RN indicated she asked and she finished putting. The RN stated the resident to per pink blanket which was on the RN stated the resident putting. The RN stated the resident poing to bring the incident to perfect the total and it was her right. #10 continued to work but sident F's room. The RN noted to the resident. The per a written warning on 1/2/11 ponse of CNA #10 to CNA #10 signed it on 1/2/11.						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG	COMPL	(X3) DATE SURVEY COMPLETED		
		155319	B. WING_		1 .	C <b>07/2011</b>		
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 375 S 11TH ST CLINTON, IN 47842					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COM (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 225	The RN also indicated note the concerns of a nursing note and Nursing's office documents of Nursing the allegation of Retailed notes and the RN indicated notes and the RN indicated notes and the RN also indicated notes and	ge 15 ted she wrote on a nursing of CNA #10 with Resident F on placed it under the Director of or. The RN did not notify the or the Administrator regarding sident F concerning CNA #10. o administrative staff talked to ent with CNA #10 and	F 225					
	indicated she had of 1/2/11. The Resider yelled at her for two The resident indicate her about everything while the CNA was while assisting her told the CNA she we picked up the call light end to both of her hands of call light away. The came in and sent the stated the nurse told Administrator since The resident stated and then a few days went to the Administrator since CNA #10 since that continued to care for Interview of the Administration of the Administr	oncerns with CNA #10 on the indicated the CNA had days (1/2/11 being day two). The concerns with CNA had days (1/2/11 being day two). The concerns with easy gand she was tired of it. So in the bathroom on 1/2/11 to bed, the resident stated she as going to report her and got to use. The resident stated of the bathroom and placed in her right arm and took the resident then stated the nurse e CNA out. The resident dher to report it to the it doesn't do them any good. She did not have any bruises a later she and her daughter trator to report CNA #10. The has not had any issues with time and indicated the CNA in her.  Ininistrator on 2/3/11 at 2:30 allegation and investigation of ent F had not been reported e was unaware of the						
	p.m., indicated the a CNA #10 and Resid to ISDH and that she allegation until 1/5 1	ellegation and investigation of ent F had not been reported						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI	LTIPLE CONSTRUCTION DING	COMPLE	(X3) DATE SURVEY COMPLETED	
		155319	B. WING	)	ŀ	C <b>7/2011</b>	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 375 S 11TH ST CLINTON, IN 47842			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 225	Continued From pa	ge 16	F 22	25	·		
·	4:55 p.m., indicated allegation with Resi written verbal warni	ector of Nursing on 2/4/11 at I she was unaware of dent F until 1/5/11 and that the ng may have been in her that she was unaware.					
	2/4/11 at 2:20 p.m., 8/20/10 of Resident rude and rushing do warning was noted, walking by room [Re employee and resid disagreement over employee say to res states CNA attempt from me.' Resident	onnel file of CNA #10 on indicated a written warning on I with complaint of CNA being uring care. A second written dated 1/2/11, of "This nurse esident F room] heard ent loudly having blanket and positioning. Heard sident 'don't bite me.' Resident ing to take call light 'away states CNA had removed her set. Blanket was across room					
	2:35 p.m., indicated 1/3/11, and 1/4/11 c 2. A facility investig	card" of CNA #10 on 2/4/11 at the CNA worked 1/2/11, on 7-3 shift. ation of abuse was received m., from the Administrator.					
	dated 1/24/11. RN: received by Resider states she does not that she is too rough she is always trying	Concern Form" was noted, #5 documented a concern at C indicating 'Resident trust staff member et (and) [with] her. She feels that to butter people up. She [CNA #9] care for her.'					
	the RN indicated she "Compliment and Co	RN #5, on 2/3/11 at 3:15 p.m., e had filled out the oncern Form" after Resident gation against CNA #9. The		·			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M A. BUI		PLE CONSTRUCTION  3	(X3) DATE SURVEY COMPLETED	
		155319	B. WIN	IG_	· · · · · · · · · · · · · · · · · · ·	l l	C <b>7/2011</b>
	ROVIDER OR SUPPLIER			37	EET ADDRESS, CITY, STATE, ZIP COD 75 S 11TH ST LINTON, IN 47842	······	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 225	RN indicated she gangle 1/24/11.  During interview of	ge 17 ave the form to the DON on the Administrator on 2/3/11 at trator indicated she was not	F2	225			
	aware of the allegat against CNA #9 und The Administrator in investigation conce against CNA #9 on indicated CNA #9 w 1/26/11, but did not Administrator indica at the end of her shallegation had been Administrator indica	tions of mistreatment made ill two days later on, 1/26/11. Indicated she implemented an rning Resident C's allegation 1/26/11. The Administrator worked the day shift on work with Resident C. The sted CNA #9 was suspended iff at 3 p.m., once the substantiated. The sted the State Department of a notified of the allegation of					
	on 2/3/11, at 3 p.m. not aware of the alk until 1/26/11.  3. A facility investig on 2/3/11 at 2:30 p.	the DON (Director of Nursing) The DON indicated she was egation made against CNA #9 ation of abuse was received m., from the Administrator.					
	interviewed on 1/26, the resident indicate taken by 'sticky fing talcum powder take taken from her and	dicated Resident B was /11. Documentation indicated ed, "I have had candy and popers, (CNA #9). Also lotion and n. My roommate had pop I have seen her (CNA#9) get ake out the bottle of cranberry it it back."					
	the RN indicated that about CNA #9 taking	RN #3 on 2/3/11 at 3:35 p.m., at Resident B had told her g items from her (Resident B) #3 indicated she told					

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL	JLTIPLE CON DING	STRUCTION		(X3) DATE S COMPL	
		155319	B. WIN	G			02/0	C 07/2011
	ROVIDER OR SUPPLIER  OF CLINTON THE			375 S 11T	RESS, CITY, STA H ST I, IN 47842	TE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PL EACH CORRECTIV OSS-REFERENCE DEF	/E ACTION SHO	OULD BE	(X5) COMPLETION DATE
F 225	me (RN #3).  During interview of 3 p.m., the Adminis	the Administrator on 2/3/11, at trator indicated she had not	F 2	25				
	Indiana State Depar Administrator indica	ion of missing property to the rtment of Health. The steed the allegation was found exestigation of allegation C.						
	2:05 p.m., the reside visit family every oth indicated when she facility she would ha The resident indicat stop bringing her ca	or of Resident G on 2/3/11 at ent indicated she goes out to her week. The resident would return back to the ave candy or lotion missing. ed she told her family to just ndy. The resident indicated to the facility "they" told her in her room.						
-	RN #4 indicated Res room one day and w the resident was up lotion was missing. weekend option, so	RN #4 on 2/4/11 at 1:40 p.m., sident G came out of her vas mad. The RN indicated set because a half of bottle of RN #4 indicated she worked she wrote a note concerning and put it under the door of the irsing).						
	2/3/11 at 3 p.m., the not aware of the alle 5. During initial tour 1:00 p.m., Resident oriented. At that time	he DON and Administrator on DON and Administrator were gations of missing items.  with LPN #1, on 2/3/11 at A was identified as alert and e, Resident A was nt A indicated about three						
. [		\$65.00 missing from a						-

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) M A. BUI		PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED C		
		155319	B. WIN	IG_		I	7/2011
	ROVIDER OR SUPPLIER OF CLINTON THE		STREET ADDRESS, CITY, STATE, ZIP CODE 375 S 11TH ST CLINTON, IN 47842				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 225	drawer in her room enters her room oth housekeeping staff	ge 19 . The resident indicated no one ner than nursing staff and . The resident indicated she ministrator and Social Service	F2	225			
	2/3/11 at 2:00 p.m. Data Set [MDS] ass	If record was reviewed on The most recent Minimum sessment, completed on e resident with no cognition					
	interviewed. The A resident was alert a Administrator indica was missing and it Administrator indica member who had to identify any certain done it. The Administrator in the Adm	.m., the Administrator was dministrator indicated the and oriented. The ated the facility verified \$50.00 was replaced on 1/5/11. The ated they thought it was a staff aken the money, but could not staff member who might have strator indicated the Indiana of Health was not notified of the					
	4/08, completed on concern of "\$50 mis [Resident A]. It was	laint/Grievance Form," dated 11/20/10, addressed the sing from hidden spot. there Thurs. [11/18/10], she 1/19/10] but it was gone after ay.					
	Takeninterview o resident's wing on 1 was made of CNAs	he form addressed Action f staff who worked on the 1/19, and 20/10. A notation staff individually interviewed amily conferred the money					
	On 2/4/11 at 12:00 p	o.m., the DON was					

#### PRINTED: 02/11/2011 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 155319 02/07/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 375 S 11TH ST WATERS OF CLINTON THE CLINTON, IN 47842 PROVIDER'S PLAN OF CORRECTION (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 225 Continued From page 20 F 225 interviewed. The DON indicated during the investigation the only resident interviewed was Resident A's roommate. 6. On 2/3/11 at 3:35 p.m., RN #3 was interviewed. The RN indicated Resident D had reported missing money, which was reported to the DON and Social Service Director [SSD]. RN #3 indicated she thought it was in November or December.

Resident D was interviewed on 2/4/11 at 10:15 a.m. The resident indicated she had not had money missing but had a bottle of liquid body soap and two new Suave deodorant sticks that she had personally purchased missing. The resident indicated she had reported it to the SSD and thought she had looked into it.

On 2/4/11 at 4:00 p.m. the SSD was interviewed. The SSD indicated she didn't know anything about it.

Review of the clinical record of Resident D on 2/4/11 at 10:05 a.m. indicated the most recent Minimum Data Set (MDS) assessment was completed 12/3/10. The assessment identified no impairment in cognition.

7. On 2/4/11 at 12:45 p.m., the Administrator was interviewed regarding reports of concern. The Administrator indicated that on 11/9/10 there was a report made by Resident E's daughter of the resident having a bottle of Olay Body Lotion missing. The Administrator indicated the investigation included a search of the resident's room and the facility was unable to locate the lotion. The Administrator indicated the lotion was replaced on 11/18/10. The Administrator indicated

Facility ID: 000212

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUII		PLE CONSTRUCTION  G	COMPL	ETED
		155319	B. WIN	G	· · · · · · · · · · · · · · · · · · ·	1	C <b>7/2011</b>
	PROVIDER OR SUPPLIER  OF CLINTON THE			37	EET ADDRESS, CITY, STATE, ZIP CODE 75 S 11TH ST LINTON, IN 47842	.,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE	(X5) COMPLETION DATE
F 225	Indiana State Depa notified of the missi the lotion.  On 2/7/11 at 12:05 interviewed. The A	rtment of Health was not ing lotion and replacement of p.m., the Administrator was dministrator indicated the form	F 2	25			
	implemented 11/1/ indicated the forms facility for residents complete and give to under her door of a Administrator indicated following up on the indicated since imp	and Concern Form" was 10. The Administrator were located throughout the families, staff, etc. to to a staff member or place ny concerns. The sted she was responsible for concerns. The Administrator lementation of the form, she any concerns to other staff for					
F 226	This Federal tag rel IN00084624. 3.1-28(c) 3.1-28(d) 3.1-28(e) 483.13(c) DEVELO		怎2:	26	This she intent of the facility to		
SS=E	ABUSE/NEGLECT, The facility must depolicies and proced mistreatment, negle and misappropriation This REQUIREMENty:	velop and implement written ures that prohibit ct, and abuse of residents n of resident property.			It is the intent of the facility to implement written policies and procedures for suspected abuse of residents and misappropriation of resident property; by immediatel reporting the occurrence to the ADM/Designee, by a thorough investigation of all staff/residents involved, and prevention of potential further abuse during investigations by not allowing staff with allegations to work until the		
	failed to implement procedures for abus				investigation has been completed and resolution has been obtained.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I IDENTIFICATION NUMBER:		ULTIF LDING	PLE CONSTRUCTION 3	(X3) DATE SURVEY COMPLETED	
		155319	B. WIN	IG		1	C 7/2011
NAME OF P	ROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE	0210	772011
WATERS	OF CLINTON THE				75 S 11TH ST LINTON, IN 47842		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	residents with allegand/or missing of part that, 1) the allegation immediately to the a (ISDH); 2) allegation investigated as all sinterviewed and/or interviewed and/or interviewed and 3) in prevented during in allegations were allegations were voc, B, G, A, D, E, F.  Findings include:  1. During initial tour Director of Nursing and oriented, utilize and was participating on 2/3/11 at 2:30 p. from investigation to Checklist," dated 1/2 by the Administrator "Report of Concern Sunday 01/02, [CN. [Resident F]. [Resident F]. [Resident F]. [Resident F] was across the she had a lot to do a Stated 'She had botto take the call light 'She jerked her hand me.' I don't know withing.' 'Stated her ar had no further compidocumentation indic "there was no intent has no prior history in the state of the	ations of physical abuse property in a sample of 22; in one were not reported administrator or other officials has were not thoroughly staff involved were not other residents were not other residents were not outther potential abuse was not vestigations as staff with owed to work after the ided by residents. (Residents on 2/3/11 at 1:20 p.m., the indicated Resident F was alerted a wheelchair, propelled self, ag in therapy currently.  In documentation was noted the "Allegations of Abuse 5/11, for Resident F provided The documentation included form, dated 1/5/11, of "On A #10] had an altercation with dent F ] wanted her blanket, room. States [CNA #10] said and was flickering her hands. In of her arms on her right arm away and my arm twisted. In daway and said Don't bite nat made her think of such a m felt sore but was fine and claints." Further ated the facility determined ional abuse. The employee no has received any prior	F 2	226	1. CORRECTIVE ACTION: An in-service was held on 2/07/11 and 02/08/11 for all staff to educate on current policies and procedures for any type of Abuse and misappropriation of resident property; which included immediate reporting to the ADM/Designee, tho investigation of all staff/residents invand prevention of potential further all during investigations, by staff not working who have had an allegations.  2. OTHERS IDENTIFIED: Social Services will complete 100% interview of all residents/family's to identify any other allegations of abuse or misappropriation of resident proper No other residents identified.  3. SYSTEMS IN PLACE: Every employee has been reinserviced 02/07 and 02/08/11 and each new hire receives the training prior to employment. Policies and procedures of allegations of any type of abuse and misappropriation of residents property, immediately reporting to ADM/Designee, thorough investigation of all staff/residents involved and prevention of potential further abuse during investigations, by staff not working if allegations are mad agains them until investigation is complete.	rough volved buse s made. see erty. dent on	
		t [Resident F] states [CNA					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		155319	B. WIN	IG		1	C <b>7/2011</b>
,	PROVIDER OR SUPPLIER  S OF CLINTON THE			375	ET ADDRESS, CITY, STATE, ZIP CODE 5 S 11TH ST INTON, IN 47842		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 226	grabbed her. CNA v positioning her in be up on CNA [CNA # exchange however, daughter] came [an arm and this report [CNA #10 was susptelephone pending Interview of RN #4 indicated on 1/2/11 hallway and heard I room. RN #4 stated bed and the door to RN indicated she en what was going on stated she wanted if the dresser and CN to bite her. The RN to leave and she fin bed. The RN stated was going to bring to Administrator's attentiold the resident to a CNA was barred from Restated no injury was RN stated she wroter egarding verbal resident F and that The RN also indicate note the concerns of a nursing note and policetor of Nursing of the allegation of Restated no indicated note the RN indicated note	rm, CNA states resident was in the process of ed[RN #4] performed write 10] on 01/02/11 for verbal on 01/05/11 [Resident F and Id] added the touching of the [and] investigation followed. Dended on 1/5/11 via investigation."  on 2/4/11 at 1:40 p.m., she was walking up the oud voices in Resident F's the resident was being put to the room was closed. The intered the room and asked to CNA #10. The resident mer pink blanket which was on A indicated the resident F to the resident indicated she asked CNA #10 ished putting Resident F to the resident indicated she	F2	226	4. MONITORING: The Administrator/Director of Nursimonitor during weekly routine QA repolicies and procedures and appropriates are taken for allegations.  ADM/Designee will review all allegof abuse and misappropriations of pas they occur to ensure protection or resident and the immediate investigation initiated.  ADM/Designee will review all allegof abuse and misappropriations of Inmonthly QA meeting with IDT a Quarterly QA meeting with the Med Director to ensure on-going compliance to the compliance of the property of the compliance of the property of	rounds roper ropriate gations roperty f the ation gations property nd in the dical ance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	155319		B. WIN	IG		I-	C <b>7/2011</b>
	ROVIDER OR SUPPLIER  OF CLINTON THE			37	ET ADDRESS, CITY, STATE, ZIP CODE 5 S 11TH ST LINTON, IN 47842		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF COR PREFIX (EACH CORRECTIVE ACTION TAG CROSS-REFERENCED TO THE A DEFICIENCY)		IOULD BE	(X5) COMPLETION DATE
	Resident F.  Interview of Resider indicated she had on 1/2/11. The Resider yelled at her for two The resident indicate her about everything while the CNA was while assisting her took the CNA she was picked up the call light end to both of her hands on call light away. The came in and sent the stated the nurse took Administrator since The resident stated and then a few days went to the Administresident stated she CNA #10 since that continued to care for Interview of the Administresident stated she CNA #10 and Resid to ISDH and that she allegation until 1/5/1 daughter came to her the Interview of the Direct 4:55 p.m., indicated allegation with Resid written verbal warning office on 1/2/11 but to the Interview of the Direct 4:55 p.m., indicated allegation with Resid written verbal warning office on 1/2/11 but to the Interview of 1/2/11 but to the Interview of 1/2/11 but to 1	nt F on 2/4/11 at 2:30 p.m., oncerns with CNA #10 on in indicated the CNA had days (1/2/11 being day two). Ited the CNA had "yelled" at g and she was tired of it. So in the bathroom on 1/2/11 to bed, the resident stated she as going to report her and ght to use. The resident stated of the bathroom and placed in her right arm and took the resident then stated the nurse e CNA out. The resident dher to report it to the it doesn't do them any good, she did not have any bruises a later she and her daughter trator to report CNA #10. The has not had any issues with time and indicated the CNA	F2	226			
	or the person	III OI OI OI OI OI					

	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII		E CONSTRUCTION		COMPL	ETED
		155319	B. WIN	IG			02/0	Ç <b>)7/2011</b>
	ROVIDER OR SUPPLIER			375	ET ADDRESS, CITY, ST. S 11TH ST NTON, IN 47842	ATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORRECT CROSS-REFERENC	LAN OF CORRECT IVE ACTION SHOU ED TO THE APPRI FICIENCY)	JLD BE	(X5) COMPLETION DATE
F 226	2/4/11 at 2:20 p.m. 8/20/10 of Residen rude and rushing d warning was noted walking by room [R employee and resid disagreement over	, indicated a written warning on t I with complaint of CNA being uring care. A second written , dated 1/2/11, of "This nurse esident F room] heard	F 2	226				
	states CNA attemp from me.' Resident pink 'Snuggie' bland on dresser."  Review of the "time 2:35 p.m. indicated 1/3/11, and 1/4/11 of 2. A facility investig	ting to take call light 'away states CNA had removed her ket. Blanket was across room card" of CNA #10 on 2/4/11 at the CNA worked 1/2/11,						
	dated 1/24/11. RN received by Reside states she does not that she is too roug she is always trying	Concern Form" was noted, #5 documented a concern nt C indicating "Resident trust staff member et (and) h [with] her. She feels that to butter people up. She e [CNA #9] care for her."						
	the RN indicated sh "Compliment and C C had made an alle	RN #5, on 2/3/11 at 3:15 p.m., e had filled out the oncern Form" after Resident gation against CNA #9. The ave the form to the DON.						
	3 p.m., the Administ aware of the allegat against CNA #9 unti The Administrator in	he Administrator on 2/3/11 at rator indicated she was not ions of mistreatment made I two days later on 1/26/11. Idicated she implemented an ning Resident C's allegation		1				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SUF COMPLET	
	÷	155319	B. Wil			02/0	C <b>07/2011</b>
1	PROVIDER OR SUPPLIER  S OF CLINTON THE			37	EET ADDRESS, CITY, STATE, ZIP CODE 75 S 11TH ST LINTON, IN 47842		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 226	indicated CNA #9 w 1/26/11, but did not Administrator indica at the end of her sh allegation had beer Administrator indica	ige 26 1/26/11. The Administrator worked the day shift on work with Resident C. The ated CNA #9 was suspended lift at 3 p.m., once the a substantiated. The ated the State Department of a notified of the allegation of	F	226			
	on 2/3/11 at 2:30 p. The investigation in interviewed on 1/26 the resident indicate taken by 'sticky fing talcum powder taken taken from her and	pation of abuse was received m., from the Administrator. dicated Resident B was /11. Documentation indicated ed, "I have had candy and popers, (CNA #9). Also lotion and m. My roommate had pop I have seen her (CNA#9) get ake out the bottle of cranberry at it back."					
	the RN indicated the about CNA #9 takin and Resident H. RI	RN #3 on 2/3/11 at 3:35 p.m., at Resident B had told her g items from her (Resident B) N #3 indicated she told uld tell someone higher than					
	3 p.m., the Administ reported the allegati Indiana State Depar Administrator indica	the Administrator on 2/3/11, at crator indicated she had not on of missing property to the tment of Health. The ted the allegation was found vestigation of allegation C.					
		of Resident G on 2/3/11 at ent indicated she goes out to				į	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI		PLE CONSTRUCTION  G	COMPLE	ETED
	,	155319	B, WIN	IG		1	C <b>7/2011</b>
	ROVIDER OR SUPPLIER OF CLINTON THE		•	37	EET ADDRESS, CITY, STATE, ZIP CODE 75 S 11TH ST LINTON, IN 47842		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 226	visit family every otl indicated when she facility she would ha	ner week. The resident would return back to the ave candy or lotion missing. ted she told her family to just	F2	226			
	RN #4 indicated Re room one day and with the resident was up lotion was missing. weekend option, so	RN #4 on 2/4/11 at 1:40 p.m., sident G came out of her was mad. The RN indicated set because a half of bottle of RN #4 indicated she worked she wrote a note concerning and put it under the door of the ursing).					
	2/3/11 at 3 p.m., the not aware of the alke 5. During initial tour 1:00 p.m., Resident oriented. At that tim interviewed. Reside months ago she had drawer in her room. enters her room oth housekeeping staff.	the DON and Administrator on a DON and Administrator were egations of missing items. It with LPN #1, on 2/3/11 at A was identified as alert and ne, Resident A was ent A indicated about three d \$65.00 missing from a The resident indicated no one er than nursing staff and The resident indicated she ministrator and Social Service					
	2/3/11 at 2:00 p.m. Data Set [MDS] ass	record was reviewed on The most recent Minimum essment completed on resident with no cognition					
	interviewed. The Acresident was alert ar	m., the Administrator was Iministrator indicated the nd oriented. The ted the facility verified \$50.00					

	FOR DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		LE CONSTRUCTION		E SURVEY PLETED
		155319	B. WIN	IG		02	C 2 <b>/07/2011</b>
	ROVIDER OR SUPPLIER		,	375	ET ADDRESS, CITY, STATE, ZIP CO 5 S 11TH ST INTON, IN 47842		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 226	was missing and it is Administrator indica member who had to identify any certain done it. The Admini State Department of missing money.	ge 28 was replaced on 1/5/11. The sted they thought it was a staff aken the money, but could not staff member who might have strator indicated the Indiana f Health was not notified of the laint/Grievance Form," dated	F2	226			
	4/08, completed on concern of "\$50 mis [Resident A]. It was	11/20/10, addressed the sing from hidden spot. there Thurs. [11/18/10], she 1/19/10] but it was gone after					
	Takeninterview or resident's wing on 1 was made of CNAs/	he form addressed Action f staff who worked on the 1/19, and 20/10. A notation /staff individually interviewed amily confirmed the money					
		ON indicated during the y resident interviewed was	·				
·	reported missing mo	5 p.m., RN #3 was N indicated Resident D had oney, which was reported to Service Director [SSD]. RN ught it was in November or					
	a.m. The resident in money missing but h soap and two new S	rviewed on 2/4/11 at 10:15 indicated she had not had had a bottle of liquid body uave deodorant sticks that burchased missing. The					

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ULTIF	PLE CONSTRUCTION  G	COMPL	(X3) DATE SURVEY COMPLETED		
		155319	B. WIN	IG_	<del></del>		C <b>7/2011</b>		
NAME OF PROVIDER OR SUPPLIER  WATERS OF CLINTON THE				37	EET ADDRESS, CITY, STATE, ZIP COD 75 S 11TH ST LINTON, IN 47842	Ξ			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
F 226	resident indicated s and thought she ha On 2/4/11 at 4:00 p	he had reported it to the SSD	F2	226					
	2/4/11 at 10:05 a.m Minimum Data Set	al record of Resident D on indicated the most recent (MDS) assessment was The assessment identified no ition.		-					
	was interviewed reg The Administrator in was a report made of the resident having missing. The Admin resident's room was unable to locate the indicated the lotion of The Administrator in Department of Heal	245 p.m., the Administrator parding reports of concernation and the facility was a searched and the facility was lotion. The Administrator was replaced on 11/18/10. Indicated Indiana State the was not notified of the eplacement of the lotion.							
	interviewed. The Actitled "Compliment a implemented 11/1/1 indicated the forms facility for residents, complete and give to under her door of ar Administrator indicated since implements."	o.m., the Administrator was dministrator indicated the form and Concern Form" was 0. The Administrator were located throughout the families, staff, etc. to a staff member or place by concerns. The ted she was responsible for concerns. The Administrator ementation of the form, she by concerns to other staff for							

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION		(X3) DATE S COMPLE	
		155319	B. WIN	4G			1	C <u>7/<b>2011</b></u>
	ROVIDER OR SUPPLIER OF CLINTON THE			37	EET ADDRESS, CITY, STATE, ZIP C 75 S 11TH ST LINTON, IN 47842	ODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOU	JLD BE	(X5) COMPLETION DATE
F 226	Review of facility cutitled "Abuse-Respondent of this facility on 2/4/11 at is the intent of this facility environment free of resident had the rig sexual, physical, as punishment, involuming properties of sometimes referredIdentification of all ways. Witness Report abuse must be tainvestigated. The repolicies and proced Based on findings of conclusion about the	irrent policy and procedure onse to Suspected," dated 1:40 p.m., indicated "Policy: It acility to maintain an abuse and neglect. The ht to be free from verbal, and mental abuse, corporal intary seclusion, and their property (collectively,	F2	2226				
	involving mistreatment property, abuse, neresident shall be im Administrator, Direct Additionally, any percent, and everyone observations that successful abuse of a designee, or staff mather allegation will talfurther potential abuse in progress3If rebelieve an event occessonsible to report Department of Healt guidelines5. The Ashall thoroughly inveevent7. If the susp	ent, misappropriation of a mediately reported to the tor of Nursing or designee(s). It is encouraged to report aggest an event has occurred. It is encouraged to report aggest an event has occurred. It is encouraged to report aggest an event has occurred. It is encouraged to report aggest an event has occurred. It is encouraged to report aggest an event has occurred, the Administrator, ember present at the time of the immediate steps to prevent use while the investigation is asonable cause exists to curred, the Administrator is to the Indiana State has per the reporting administrator or designee astigate all allegations of an ected perpetrator is an lity, he/she will be suspended						

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		LE CONSTRUCTION	(X3) DATE S	ETED
		155319	B. WIN	۱G	· · · · · · · · · · · · · · · · · · ·	02/0	C <b>)7/2011</b>
	ROVIDER OR SUPPLIER OF CLINTON THE		•	37	EET ADDRESS, CITY, STATE, ZIP COD 5 S 11TH ST LINTON, IN 47842	E	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PRÓVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION & CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 226	The Director of Nur Documentation and the event is comple suspected misapper for which you must Property Investigati investigation related shall be reported to officials as soon as accordance with States and Procedure: Occurre are required by law within 24 hours of o Care Division CFR facility must ensure involving mistreatmincluding injuries of misappropriation of immediately to the ato other officials in a through established State Survey and CReview of facility cutitled "Abuse Prohib at 1:40 p.m., indicate Resident Property: exploitation, or wron	on has been completed9. sing shall ensure the Incident Investigation Tool regarding ited unless the event is ropriation of resident property use the Misappropriation of on Report12. Results of the it to the resident's incident the Department of Health reasonably possible, in ate and Federal Law"  Internet policy and procedure nusual Occurrences," dated 1:40 p.m., indicated " ences to be reported: Facilities to report unusual occurrences ccurrence to the Long Term 483.13(c)(2) states that 'the that all alleged violations ent, neglect, or abuse, unknown source and resident property are reported administrator of the facility and accordance with State Law procedures (including to the ertification Agency."  Trent policy and procedure ition" dated 6/1/10 on 2/4/11 ed "Misappropriation of The deliberate misplacement, agful temporary or permanent belongings or money without ent"	F 2	226			

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		COMPL	(X3) DATE SURVEY COMPLETED	
		155319	B. WING	3	1	C )7/ <b>2011</b>	
	PROVIDER OR SUPPLIER  S OF CLINTON THE			STREET ADDRESS, CITY, STATE, ZIP COI 375 S 11TH ST CLINTON, IN 47842			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 226	Continued From pa 3.1-28(a)	ge 32	F 22	26		·	
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